Clark County Regional Support Network

# Inpatient Voluntary Authorization – Extension - Form

## CALLER INFORMATION

Date:_____ Time of Call or Page:_____AM/PM Time of CM Response:_____AM/PM

Name of Caller:_____ Title/Credential:_____

Agency:_____ Phone:_____

Date of Patient Evaluation:_____ Time of Patient Evaluation:_____

**NAME of PATIENT:**_____ DOB: :_____

**MEDICAL NECESSITY** (Risk Assessment/Acuity/Function/Support/Environment/Alternatives Explored) _____

## PSYCHIATRIC CONSULTATION

(*Required for all child and adolescent authorization requests and for all potential denials (child and adult).*)

Name of Consultant:_____ Time Called Consultant:_____ Time Call Returned:_____

Results of Consult:_____

## RESULT OF REVIEW:

☐ APPROVED ☐ DIVERTED Plan:_____

Hospital agrees with diversion? ☐ Yes ☐ No = **GO TO DENIED**

☐ DENIED Primary Reason: ☐ Not financially eligible ☐ Less restrictive alternative ☐ DD is primary ☐ A & D is primary ☐ Not a covered MH diagnosis ☐ Low acuity

**AUTHORIZATION DECISION DATE:** Date:_____ Time:_____AM/PM Care Manager:_____